

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8395 CERTIFICATE OF DEATH

Reg. Dist. No. 88373
382

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>8 hrs</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bent + Queen Anne's Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <u>Baby</u>	Middle <u>Boy</u>	4. DATE OF DEATH Last <u>Atkinson</u> Month <u>August</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 7, 1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u> <u>America</u>		
13. FATHER'S NAME <u>Alvin Brown Atkinson</u>		14. MOTHER'S MAIDEN NAME <u>Mae Vivian Holliday</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>173-5</u>		
17. INFORMANT <u>Mother</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital debility</u> DUE TO <u>773.5</u> INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO <u>773.5</u> (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Millington</u> (County) <u>Md.</u> (State) <u>Md.</u>
21. I certify that I attended the deceased from <u>Aug 7, 1956</u> to <u>Aug 7, 1956</u> , that I last saw the deceased alive on <u>Aug 7, 1956</u> , and that death occurred at <u>124</u> M, from the causes and on the date stated above.				
ACTUAL SIGNATURE <u>George Kowalewski</u>		ADDRESS (Street, city or town, state) <u>Millington Md. 21601</u> DATE SIGNED <u>Aug 7, 1956</u>		
PHYSICIAN'S NAME (Type) <u>GEZA KOWALEWSKI</u>		M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 9, 1956</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Wesley Chapel Cemetery</u>	22d. LOCATION (City, town, or county) <u>Rock Hall</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Tilbur Millington Md.</u>		ADDRESS	24a. REC'D BY REGISTRAR <u>Aug 13, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Clara Barnes</u>

CERTIFICATE OF DEATH

NAME

ADDRESS

PHONE

AGE

SEX

CAUSE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF DOCTOR

NAME OF HOSPITAL

NAME OF FUNERAL HOME

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

NAME OF ATTENDING DOCTOR

NAME OF ATTENDING NURSE

BUREAU V.

Aug 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8396

CERTIFICATE OF DEATH

118374

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 123 Washington Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d. STREET ADDRESS 123 Washington Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First Marian	Middle Josephine	Last Lusby	4. DATE OF DEATH Aug. 31, 1956	Month Aug.	Day 31	Year 1956
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S. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 14, 1872	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Kent CO. Maryland	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Josiah Lusby	14. MOTHER'S MAIDEN NAME Emily Usilton
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S. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT Miss Mary Nicholson	Address Chestertown, Md.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>		<u>1 1/2 years</u>
199.8 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO
(b) <u>Carcinoma of sigmoid and</u>		<u>2 Both lungs</u>
DUE TO		
(c) <u>Carcinoma of breast</u>		<u>than 1/2 year</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
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20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>55</u> , to <u>8/31</u> , 19 <u>56</u> that I last saw the deceased alive on <u>8/31</u> , 19 <u>56</u> , and that death occurred at <u>11:30 a.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Farr</u>		ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u>	DATE SIGNED <u>8/31/56</u>

PHYSICIAN'S NAME (Type)	Robert W. Farr - Chestertown, Md.		
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 2, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown, Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>	ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR DATE Sept. 4, 1956	24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>
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CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
SEP 6 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18375

8397

CERTIFICATE OF DEATH

Reg. Dist. No. 2021

1. PLACE OF DEATH a. COUNTY KENT		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 CHESTERTOWN		c. LENGTH OF STAY IN 1b 7 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD		b. COUNTY QUEEN ANNE'S	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT + QUEEN ANNE'S		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BARCLAY		d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE		First	Middle	Last	4. DATE OF DEATH AUG 24	Month	Day	Year	
5. SEX M		6. COLOR OR RACE COL	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JAN 30, 1879	9. AGE (in years last birthday) 77 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM LABORER		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME BILLY SIMMONS		14. MOTHER'S MAIDEN NAME MARY GARRISON.		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown.) UNK		16. SOCIAL SECURITY NO. None		17. INFORMANT HOSPITAL CHART.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO GENERALIZED CARCINOMATOSIS (PRIMARY SITE UNKNOWN). (c)									
INTERVAL BETWEEN ONSET AND DEATH 1 WEEK									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from AUG 20, 1956 to AUG 24, 1956, that I last saw the deceased alive on AUG 24, 1956, and that death occurred at 11:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE ARTHUR T. KEEFE, JR. M.D. CHESTERTOWN, MD. AUG 24, 1956									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/29/56		22c. NAME OF CEMETERY OR CREMATORIAL Barclay		22d. LOCATION (City, town, or county) Barclay		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaire		ADDRESS Greensboro, Md.		24a. REC'D BY REGISTRAR Aug 27, 1956		24b. REGISTRAR'S SIGNATURE Class S. Barnes.			

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68376
 Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY		8398 Kent	MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		a. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Chestertown		12 years		Chestertown		Calvert St.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		Calvert St.				
Calvert St.										

3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Jean				Brown	Aug. 25, 1956			

5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1YEAR	11. IF UNDER 24 HRS.		
female	colored	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 17, 1937	19 yrs.	Months	Days	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework			Queen Anne Co. Maryland	USA

13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Charles Brown		Martha May Sparks	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT	Address
(If yes, give war or dates of service)		no	Charles Brown	Calvert St. Chestertown, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Bullet wounds in the abdomen with damage DUE TO to kidney, liver and hemorrhage		few minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		
		DUE TO		
		(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. 8/25 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Calvert St.	20f. (City or town) Chestertown	(County) Kent	(State) Md.
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21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>						
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ACTUAL SIGNATURE <i>Robert W. Farr</i>	DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
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EXAMINER'S NAME (Type)	Aug. 27, 1956					
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22a. BURIAL, CREMATION REMOVAL (Specify)	22b. DATE THEREOF Aug. 29, 1956	22c. NAME OF CEMETERY OR CREMATORY Rich Neck Hall Cem.	22d. LOCATION (City, town, or county) near Church Hill	(State) Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>	ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR Aug. 29-56	24b. REGISTRAR'S SIGNATURE <i>Class. Barnes</i>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

BUREAU V. S

AUG 31 1956

FBI - BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

188377

Item 18 Film G202 9-14-56 ams

8407

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Piney Neck		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
3. NAME OF DECEASED (Type or print) MARY ANNA COTTON		d. STREET ADDRESS Piney Neck	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Rock Hall, Md.
13. FATHER'S NAME William Tilghman		14. MOTHER'S MAIDEN NAME Sarah Saunders	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-03-4430	17. INFORMANT Address Mrs. Geneva Sisco, Rock Hall, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Sisco, Geneva / Marvin (c) DUE TO Unknown Unknown			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) Massive pulmonary hemorrhage due to chronic pulmonary tuberculosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 20</u> , 1956, to <u>Aug 31</u> , 1956, that I last saw the deceased alive on <u>Aug 29</u> , 1956, and that death occurred at <u>7:50 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Norbet C. Nitch</u> M.D. ADDRESS (Street, city or town, state) <u>Rock Hall, Md.</u> DATE SIGNED <u>1956</u>			
PHYSICIAN'S NAME (Type) Norbet C. Nitch M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Sept. 3/56		22c. NAME OF CEMETERY OR CREMATORIUM Edsville Cemetery	
22d. LOCATION (City, town, or county) Rock Hall, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams, Chestertown, Md.		24a. REC'D BY REGISTRAR DATE <u>Sept 3/56</u>	
		24b. REGISTRAR'S SIGNATURE <u>S. Sherrard Braggs</u>	

STATE DEPARTMENT OF HEALTH - BALTIMORE 18
CERTIFICATE OF DEATH

BUREAU Y.
RECEIVED
SEP 6 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08378

8399

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH
o. COUNTY

Kent

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

38 Chestertown

c. LENGTH OF STAY IN 1b
8 daysd. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

72 Kent and Queen Ann

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland

b. COUNTY Kent

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Betterton

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
Eva

Middle

Last
Davis4. DATE
OF
DEATH
August 3
1956Month
AugustDay
3Year
19565. SEX
Female6. COLOR OR RACE
White7. MARRIED NEVER MARRIED
WIDOWED DIVORCED 8. DATE OF BIRTH
Nov. 9, 18849. AGE (In years
last birthday)
72 yrs.10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)
housewife11. KIND OF BUSINESS OR INDUSTRY
12. CITIZEN OF WHAT COUNTRY?
Virginia U.S.A.

13. FATHER'S NAME

Samuel T. Bassett

14. MOTHER'S MAIDEN NAME

Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.
—

17. INFORMANT

Address

None

Hosp. records Chestertown, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive heart failure

INTERVAL BETWEEN
ONSET AND DEATH
8 days

442X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b) Myocarditis

1 year?

DUE TO

Cardiovascular renal disease

1 year?

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

Obesity

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 7-27, 1956, to 8-3, 1956, that I last saw the deceased
alive on 8-3, 1956, and that death occurred at 9:10 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

A. C. Dick M.D.

Chestertown, Md.

8-3-56

PHYSICIAN'S
NAME (Type)

A. C. Dick

22a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL 8-6-5622b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORIUM
PARKWOOD CEMTY22d. LOCATION (City, town, or county)
(State)
BALTIMORE, MD.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS
Victor N. Kennedy STILL POND, MD.24a. REC'D BY REGISTRAR
DATE 8/4/5624b. REGISTRAR'S SIGNATURE
E. Leonard Jones

CERTIFICATE OF DEATH

Date of Birth

Cause of Death

Place of Death

Name of Physician

Name of Hospital

Name of Coroner

Name of Pathologist

Name of Mortician

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Mortuary

Name of Funeral Director

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Mortuary

Name of Funeral Director

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Mortuary

Name of Funeral Director

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Mortuary

Name of Funeral Director

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Mortuary

Name of Funeral Director

BUREAU V.

AUG 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

68379

8408

CERTIFICATE OF DEATH

Reg. Dist. No. 2102

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown R.F.D.		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Circle) Strong Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton	
3. NAME OF DECEASED (Type or print) George Hilton		d. STREET ADDRESS Worton Point	
4. DATE OF DEATH Aug. 25, 1956		Month Aug.	Day 25
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1894	
9. AGE (In years lost birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME A. Remie Fogwell		14. MOTHER'S MAIDEN NAME Mary Carrie Rodney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Katie Fogwell		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 356.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) Tobac pneumonia	
		INTERVAL BETWEEN ONSET AND DEATH 1 week	
19. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive vascular disease	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 1956, to <u>Aug. 25, 1956</u> , that I last saw the deceased alive on <u>August 24, 1956</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Willard F. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 29, 1956	
22c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel		22d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
22e. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		24a. REC'D BY REGISTRAR Date 9-29-1956	
		24b. REGISTRAR'S SIGNATURE Clara J. Barnes	

TO HOSPITAL OR
may be retained
the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

AUG 31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, See: Birth Cert.

188380

8400

CERTIFICATE OF DEATH

Reg. Dist. No. 21021

1. PLACE OF DEATH a. COUNTY <i>Kent</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Queen Anne's</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chestertown</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Saint Church Hill</i>		d. STREET ADDRESS <i>178-2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kent & Queen Anne Hospital</i>				d. STREET ADDRESS <i>178-2</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Ernest Gary</i>		First	Middle	Last	4. DATE OF DEATH <i>GEORGE</i>	Month	Day	Year	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/28/56</i>	9. AGE (in years lost birthday) yrs. <i>1</i>	IF UNDER 1 YEAR Months <i>3</i>	IF UNDER 24 HRS. Days <i>3</i>	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Ernest Edward George</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Margaret Reid</i>		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>776 X</i>		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity (32 weeks)</i>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>776 X</i>		(b) DUE TO		(c) DUE TO					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Intrapartum asphyxia, due to prematurity/placenta separation</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>19</i>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert W. Fair</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>8/31/56</i>							
PHYSICIAN'S NAME (Type) <i>ROBERT W. FAIR</i>		22. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>							
22b. DATE THEREOF <i>Sept. 1/56</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Church Hill</i>		22d. LOCATION (City, town, or county) <i>Church Hill Md</i>			(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marvin V. Williams - Chestertown Md</i>		ADDRESS <i>178-2</i>		24a. REC'D BY REGISTRAR <i>Sept. 4/1956</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Barnes</i>			

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGON, D. C.

CERTIFICATE OF SERVICE

FEDERAL BUREAU OF INVESTIGATION

SEP 6 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

88382

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY KENT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		c. LENGTH OF STAY IN 1b 1 WEEK		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT & QUEEN ANNE'S Hosp		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LOCUST GROVE		
3. NAME OF DECEASED (Type or print) WILLIAM		d. STREET ADDRESS		
4. DATE OF DEATH AUG 24 1956		Month	Day	
5. SEX MAL	6. COLOR OR RACE COL	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAY 2 1908	
9. AGE (In years last birthday) 48 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	
13. FATHER'S NAME WILL HENDERSON	14. MOTHER'S MAIDEN NAME LIZZIE HANCOCK	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNK		
16. SOCIAL SECURITY NO. 243-16-7141		17. INFORMANT HOSPITAL CHART	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 541.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) PER INTESTINAL OBSTRUCTION DUE TO (c) PERFORATED DUODENAL ULCER		INTERVAL BETWEEN ONSET AND DEATH 48 HRS.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG 16, 1956 , to AUG 24, 1956 , that I last saw the deceased alive on AUG 24, 1956 , and that death occurred at 6:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 8/24/56				
ACTUAL SIGNATURE <i>Arthur T. Keeffe</i>		PHYSICIAN'S NAME (Type) ARTHUR T. KEEFE, JR. M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/26/1956	22c. NAME OF CEMETERY OR CREMATORIAL Janes Cem.	22d. LOCATION (City, town, or county) Chestertown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR Aug. 27-56	24b. REGISTRAR'S SIGNATURE Charles Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-travel Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

AUG 29 1956

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18383

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH a. COUNTY		8409		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
KENT		MARYLAND		b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
ROCK HALL				ROCK HALL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS	
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First NELLIE	Middle GRANT	4. DATE OF DEATH	Month AUG. Day 6 Year 1956
5. SEX FEM.		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH 9-2-1875	9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE				MARYLAND	
13. FATHER'S NAME DANIEL WEBSTER AIRES		14. MOTHER'S M AIDEN NAME MARY L. LLOYD		12. CITIZEN OF WHAT COUNTRY USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. MARY BEEKMAN - Rock Hall Md	
				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Peritonitis of unknown etiology</i> INTERVAL BETWEEN ONSET AND DEATH 1 week					
576X DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Arteriosclerosis, cerebral; congestive heart failure					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
p. m.					
21. I certify that I attended the deceased from Jan. 1, 1956, to Aug. 6, 1956, that I last saw the deceased alive on Aug. 6, 1956, and that death occurred at 6 P.M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Willard F. Smith</i> M.D. ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED 8/8/56					
PHYSICIAN'S NAME (Type) WILLARD F. SMITH					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF AUG. 9		22c. NAME OF CEMETERY OR CREMATORIAL WESLEY CHAPEL	
22d. LOCATION (City, town, or county) ROCK HALL		(State) MD.			
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane ADDRESS					
24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE 8/9/56 S. Elwood Braggs					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU Y-1

Aug 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18384

8410

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH a. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE KD. b. COUNTY KENT				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLINGTON		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLINGTON		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First MARY	Middle T.	Last JARVAN	4. DATE OF DEATH	Month AUG.	Day 19	Year 1937
S. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 25, 1875	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWORK		11. BIRTHPLACE (State or foreign country) MD.	12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME ROBERT THOMPSON		14. MOTHER'S MAIDEN NAME unknown		Address Leonard Bubinian millington md				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —		17. INFORMANT S. Trope	INTERVAL BETWEEN ONSET AND DEATH 3 days			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gen. Arteriosclerosis DUE TO 10 years (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) MILLINGTON	(County) Md.	(State) Md.
21. I certify that I attended the deceased from Dec 6 , 1937 to Aug 19 , 1937 that I last saw the deceased alive on Aug 18 , 1937, and that death occurred at 12 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE H. H. Hamilton				ADDRESS (Street, city or town, state) M.D. MILLINGTON MD		DATE SIGNED 8/23/37		
PHYSICIAN'S NAME (Type) H. H. HAMILTON								

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/24/56	22c. NAME OF CEMETERY OR CREMATORIAL CRUMPTON CEN.	22d. LOCATION (City, town, or county) CRUMPTON, D. C. MD.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows.		ADDRESS MILLINGTON MD.	24a. REC'D BY REGISTRAR DATE 8/27/56
			24b. REGISTRAR'S SIGNATURE Eliz. Mulford

BUREAU V. S.

9561 25.1.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18385

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION near Tolchester		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
3. NAME OF DECEASED (Type or print) Clara		d. STREET ADDRESS near Tolchester	
4. DATE OF DEATH August 24	Month Year 1956	Day	Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1868
9. AGE (In years (1st birthday) 87 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Prince Geo. Co. Md.	11. BIRTHPLACE (State or foreign country) Prince Geo. Co. Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME unknown	14. MOTHER'S MAIDEN NAME St. Clair	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. no	17. INFORMANT St. Clair Martenet	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Arteriosclerosis (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH Week several years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on	Jan. 1953, to August 24, 1956	that death occurred at 12 noon	ADDRESS (Street, city or town, state) Rock Hall, Md.
ACTUAL SIGNATURE Willard F. Smith	M.D.	DATE SIGNED 8/27/56	
PHYSICIAN'S NAME (Type) Willard F. Smith	22. BURIAL, CREMATION, REMOVAL (Specify) Burial		
22b. DATE THEREOF 8/27/56	22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cem.	22d. LOCATION (City, town, or county) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells	24a. REC'D BY REGISTRAR DATE 8/27/56	24b. REGISTRAR'S SIGNATURE S. Sherrill Burgess	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
BUREAU Y. S.

AUG 29 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118386

Reg. Dist. No. 201

1. PLACE OF DEATH a. COUNTY		8411 Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Rural Kennedyville Park 1 day		d. STATE		a. STATE Delaware b. COUNTY New Castle	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Howard		First R Middle		McCleure Jr.		Wilmington 116-7	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10-12-1934	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
21 yrs.		19		19 056			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Apprentice Florist Retail Florist				Delaware		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Howard R. McCleure, Sr		Isabelle Pierson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Cecilton Md +	
No				L. F. Devine Jr			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 929.8 Drowning DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)							
DUE TO							
C (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I(a) of item 20b)							
Drowned while swimming at a swimming hole on 8/19/56 in Sassafras River, near Kennedy Park							
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)
Hour 12:12		p.m.	8/19 1956		While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		State Delaware
20g. (County) Kent							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE		ROBERT W. FARR		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/21/56	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)	
Burial		8-22-56		Gloucester Memorial Park Fairstoest Delaware		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Edward Ellour Millington Md.				DATE 8/27/56		C. Kennard Jones	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

STATE OF MASSACHUSETTS
MEDICAL EXAMINER - DEPARTMENT OF PUBLIC SAFETY

BUREAU V. 2

W.G. 97 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18387

8403

CERTIFICATE OF DEATH

Reg. Dist. No 202

1. PLACE OF DEATH a. COUNTY		Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STATE Maryland	
Chestertown		6 Mo.		b. COUNTY Kent	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
532 Cannon St.		Chestertown		e. STREET ADDRESS Scotts Pt.	
3. NAME OF DECEASED (Type or print)		First MARY ANN MEEKINS	Middle	Last	4. DATE OF DEATH Aug. 25 1956
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1876	9. AGE (In years lost birthday) 79 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Worton, Kent Co. Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Younger		14. MOTHER'S MAIDEN NAME Mary Coleman		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Joseph Long, Chestertown, Md.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Terminal bronchopneumonia - 6 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Stroke (hemiplegia) and 4 X 6 (c) DUE TO arteriohypertension monthly	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Worton	(County) Kent Co. (State) Md.
21. I certify that I attended the deceased from 7/12, 1956, to 8/26, 1956, that I last saw the deceased alive on 8/26, 1956, and that death occurred at 10:30 A.M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Robert W. Farr</i>		M.D.		ADDRESS (Street, city or town, state) Chestertown, Maryland	DATE SIGNED 8/28/56
PHYSICIAN'S NAME (Type) Robert W. Farr, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 29/56	22c. NAME OF CEMETERY OR CREMATORIUM Union Cemetery	22d. LOCATION (City, town, or county) Worton	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams, Chestertown, Md.		ADDRESS		24a. REC'D BY REGISTRAR Aug. 30-1956	24b. REGISTRAR'S SIGNATURE Clara S. Bussey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 4 1956

RECEIVED

1 MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

88388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		8412 Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
		MARYLAND		a. STATE Pennsylvania b. COUNTY Delaware	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Drexell Hill		75-2		Drexell Hill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
				728 Edmonds Ave	
e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
BRUCE		EMILE	Morlock	Aug 3	Month Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)
Male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug 29, 1950	5 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Pennsylvania	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
George A. Morlock		Jean Graham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no				George A. Morlock, Drexell Hill Pa	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				Address	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Probable drowning.		INTERVAL BETWEEN ONSET AND DEATH	
929.0		DUE TO		a few minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)			
		DUE TO			
		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c)				19. WAS AUTOPSY PERFORMED?	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter for external cause)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
7/2 1956		While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20f. (City or town)	
				(County) (State)	
				Galena Kent Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ROBERT W. FARK		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		August 3, 1956	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL	
Burial		Aug 7 1956		Valley Forge Cemetery	
22d. LOCATION (City, Town, or county) (State)				Phila. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D. BY REGISTRAR	
Edward Yellow Millington Md				DATE 8/8/56	
24b. REGISTRAR'S SIGNATURE				Elizabeth J. Mulford	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WEDDING CERTIFICATE OF DEATH
WEDDING CERTIFICATE OF DEATH

BUREAU V. S.

AUG 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18389

8404

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY KENT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ruth Queen Anne		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Chestertown	
d. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN		First F.	Middle NEWCOMB
4. DATE OF DEATH AUGUST 11 1956		Month	Day
S. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/19/1894
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Newcomb		14. MOTHER'S MAIDEN NAME McIsaac Diehl	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-30-0824	
17. INFORMANT Walter Hadaway, Chestertown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 913.0		INTERVAL BETWEEN ONSET AND DEATH 3 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Stans	
DUE TO Caecum on left index finger		8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) Cut finger while mowing grass	
20c. TIME OF INJURY Hour o. m. 8 p. m. 3		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Chestertown		(County) Rut	
(State) Md.		21. I certify that I attended the deceased from 8/9 , 1956, to 8-11 , 1956, that I last saw the deceased alive on 8-11 , 1956, and that death occurred at 12049 M, from the causes and on the date stated above. ACTUAL SIGNATURE Ruth Farr	
PHYSICIAN'S NAME (Type) ROBERT W. FARR		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/13/56	22c. NAME OF CEMETERY OR CREMATORIAL WESLEY CHAPEL
22d. LOCATION (City, town, or county) Rock Hall, Md.		(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lingley, Jr.		24a. REC'D BY REGISTRAR Aug. 14-56	24b. REGISTRAR'S SIGNATURE Clara L. Barnes
ADDRESS Church Hill, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH	DEATH CERTIFICATE NUMBER
WILLIAM H. HARRIS						
60						
M						
1956						
10:00 AM						
Diseases of heart						
100-12345678						

BUREAU U. S.

AUG 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8405

CERTIFICATE OF DEATH

Reg. Dist. No.

88390
202

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Ellsworth	Middle Smith	Last Smith	4. DATE OF DEATH Aug. 9,	Month 1956	Day Year 19 56
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1888	9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY various		11. BIRTHPLACE (State or foreign country) Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaac Smith				14. MOTHER'S MAIDEN NAME Catherine Toomey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-16-9583		17. INFORMANT Mrs. Eleanor Murray		Address Calvert St. Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO Rectum (c)				INTERVAL BETWEEN ONSET AND DEATH 6 months at least 6 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterial hypertension with failure - several years				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/18, 1956, to 8/9, 1956, that I last saw the deceased alive on 8/9, 1956, and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Robert W. Farr</i>		M.D. Chestertown, Md.					
PHYSICIAN'S NAME (Type) Robert W. Farr - Chestertown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 11, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Janes (Col.) Cem.		22d. LOCATION (City, town, or county) Chestertown, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR Aug. 11-1956		24b. REGISTRAR'S SIGNATURE <i>Clara L. Barnes</i>	

STATE OF HAWAII - GOVERNOR'S OFFICE
CERTIFICATE OF DEATH

BUREAU V. E.

AUG 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8406

CERTIFICATE OF DEATH

18391

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesterlawn		c. LENGTH OF STAY IN 1b 3 1/2 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) Kent and Anne Arches Hosp		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl		4. DATE OF DEATH TEAT August 17 1956	Month Day Year
5. SEX Female	6. COLOR OR RACE Coloured	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/16/56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Charles Edward Teat		14. MOTHER'S MAIDEN NAME Sarah Drucilla Teller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Sarah Teat Nullington, Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 760.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Lemorrhage, convulsions (Delirium) about 5-8 minutes DUE TO (c) Excuse me size 12# 1/3 (EDC Aug 20 1956) INTERVAL BETWEEN ONSET AND DEATH 31 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Stretcher - left arm (Sustained puncture wound blood in shoulder)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state) Chesterlawn, Md	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-16, 1956, to 8/17, 1956, that I last saw the deceased alive on 8-17, 1956, and that death occurred at 8:45 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chesterlawn, Md DATE SIGNED 8/17/56			
ACTUAL SIGNATURE ROBERT W. FARR PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 1956	22c. NAME OF CEMETERY OR CREMATORIAL Mt Pleasant
22d. LOCATION (City, town, or county) Chesterlawn		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chesterlawn		24a. REC'D BY REGISTRAR Aug 20-56	24b. REGISTRAR'S SIGNATURE Clara S. Barnes
VS A15 (4) 15M 9/55			

BUREAU Y. S.

Aug 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18392

8413

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coleman's Corner		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION near - Still Pond, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coleman's Corner near Still Pond	
3. NAME OF DECEASED (Type or print) Phillip		d. STREET ADDRESS	
4. SEX Male		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. COLOR OR RACE colored		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. B. DATE OF BIRTH Nov. 11, 1867		8. DATE OF DEATH Aug. 2, 1956	
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Dots Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener & Farmer		10b. KIND OF BUSINESS OR INDUSTRY Laborer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Phillip Wright		14. MOTHER'S MAIDEN NAME Mary Jane Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] no		16. SOCIAL SECURITY NO. Don't know	
17. INFORMANT Mrs. Lillian Ringgold		Address Coleman's Corner Still Pond, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchitis</u> DUE TO 501X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>Cured by cold.</u> DUE TO (c) <u>Exposure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>220</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>220</u>	
20c. TIME OF INJURY Hour o. m. 200 p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> of work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>not any</u>		20f. (City or town) <u>Baltimore</u>	
(County) <u>Kent</u>		(State) <u>2nd</u>	
21. I certify that I attended the deceased from <u>July 31, 1956</u> , to <u>Aug 1, 1956</u> , that I last saw the deceased alive on <u>Aug 1, 1956</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>L. P. Atwell</u> ADDRESS (Street, city or town, state) L. P. Atwell - Still Pond, Maryland DATE SIGNED <u>Still Pond 2nd</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/5/1956	
22c. NAME OF CEMETERY OR CREMATORIUM Coleman's Cem.		22d. LOCATION (City, town, or county) Coleman's Corner	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		24a. REC'D BY REGISTRAR DATE 8/4/56	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE <u>Edmund Jones</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

UG 7 1956

RECEIVED